DDD-1332AFORNA (7-03)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

INDIVIDUAL SUPPORT PLAN/INDIVIDUALIZED FAMILY SERVICE PLAN
INDIVIDUAL ATTRIBUTE CHECKLIST

INDIVIDUAL'S NAME *(Last, First, M.I.)*		DATE
ASSISTS ID NO.	ELIGIBILITY ☐ ALTCS ☐ TSC ☐ Foster Care ☐ DDD *(only)* ☐ AZEIP	DATE OF BIRTH

- List the service(s) at the top of each column. If there are more than 5 services, attach another checklist.
- In each column, provide requested information and check the attributes that must be considered when receiving the service(s).
- The service amount identified on this document does not constitute approval.

	SERVICE	**SERVICE**	**SERVICE**	**SERVICE**	**SERVICE**
Service(s)					
Service Amount					
Service need date					
Qualified vendor	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Independent provider	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Auto Assign	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
List days and time you are available to receive the service.					
Who will contact potential providers to confirm availability?					
Cross streets, community and/or city where you are located.					
If you have identified the service provider in advance, please specify.					
INDIVIDUAL CHARACTERISTICS:					
Autism					
Mental retardation					
Cerebral palsy					
Epilepsy					
At risk					
Movement limitations					
Vision limitations					
Hearing limitations					
Communication limitations					
Alzheimer's/dementia					
Non-ambulatory					
Location of service	☐ In-home ☐ Out-of-home ☐ No preference	☐ In-home ☐ Out-of-home ☐ No preference	☐ In-home ☐ Out-of-home ☐ No preference	☐ In-home ☐ Out-of-home ☐ No preference	☐ In-home ☐ Out-of-home ☐ No preference
Assistive technology					
Augmentative communication device					
G-tube feeding/cleaning					
Toileting					
Positioning					
Mobility and gait training					

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PROVIDER EXPERTISE:	**SERVICE**	**SERVICE**	**SERVICE**	**SERVICE**	**SERVICE**
Positive behavior support					
Client Intervention Techniques (CIT) Level 1					
Client Intervention Techniques (CIT) Level 2					
Spanish speaking					
Sign language					
Other language *(Specify)*					
Gender preference requested by individual *(Specify one)*	☐ Male ☐ Female ☐ No preference	☐ Male ☐ Female ☐ No preference	☐ Male ☐ Female ☐ No preference	☐ Male ☐ Female ☐ No preference	☐ Male ☐ Female ☐ No preference
Medication monitoring/administration					
Implementing/following therapy home programs					
Carry/lift under 50 lbs.					
Carry/lift over 50 lbs.					
THERAPY PROVIDER EXPERTISE:					
Oral motor/feeding/swallowing					
Neuro-developmental therapy					
Auditory integration					
Sensory integration					
Cranial sacral					
Home modification					
Tscharnuler Akademie for Movement Organization (TAMO)					

SUPPORT COORDINATOR'S NAME *(Please Print)*	PHONE NO. ( )

INDIVIDUAL/RESPONSIBLE PERSON'S NAME *(Please Print)*

INDIVIDUAL/RESPONSIBLE PERSON'S SIGNATURE	DATE

Equal Opportunity Employer/Program ♦ Under the Americans with Disabilities Act (ADA), the Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. For example, this means that if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. This document is available in alternative formats by contacting (602) 542-6825.